

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07778

7788

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARTFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARTFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Darlington Rural</u>		<u>2 Years</u>		TOWN <u>Darlington Rural</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>LAURA</u> (Middle) <u>F</u> (Last) <u>ALBERT</u>				<u>Aug 12</u> 19 <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>MAR 10-1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Mrs Raymond Coverday</u> <u>Darlington MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>153X</u> IMMEDIATE CAUSE (A) <u>Carcinoma of Colon</u>				<u>1 yr</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>260X</u> (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes</u>							
19. DATE OF OPERATION <u>March 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Colon</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 54</u> , to <u>Aug 55</u> , that I last saw the deceased alive on <u>July 55</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Malcolm Dudley Phillips</u>				ADDRESS (Street, city, town, state) <u>Darlington Md</u>		DATE SIGNED <u>8/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Aug 15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Southern Methodist</u>		LOCATION (City, town, or county) (State) <u>Darlington Md</u>	
24. REC'D BY REGISTRAR DATE <u>8-15-55</u>		REGISTRAR'S SIGNATURE <u>Priscilla Howard</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. John Belton</u>			

RECEIVED

AUG 17 1955

BUREAU V. S.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - RAILROADS

1955

RECEIVED

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH - RAILROADS, DIVISION OF VITAL RECORDS, IN THE CITY AND COUNTY WHERE THE DECEASED WAS USUALLY RESIDENT AT THE TIME OF DEATH. IT IS TO BE RETURNED TO THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH - RAILROADS, DIVISION OF VITAL RECORDS, IN THE CITY AND COUNTY WHERE THE DECEASED WAS USUALLY RESIDENT AT THE TIME OF DEATH. IT IS TO BE RETURNED TO THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7773

CERTIFICATE OF DEATH

07779

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md.</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Har-de-Grace</u>				TOWN <u>Aberdeen</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>R.D. # 1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Mary Jane Archer</u>				<u>8 17 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Aug 16-1889</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>House-Wife</u>		<u>Livezey</u>		<u>Maryland</u>		<u>US</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert H. Livezey</u>				<u>Annie Schwartz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>James G. Archer</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>Cerebral Thrombosis</u>						<u>48 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
<u>Arteriosclerotic Cardiovascular Disease</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8/15, 1955</u>, to <u>8/17, 1955</u>, that I last saw the deceased alive on <u>8/17, 1955</u>, and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Frederick J. Hatten</u>				<u>Phil. Blvd, Aberdeen Md</u>		<u>8/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 20 55</u>		<u>Mt Carmel Methodist</u>		<u>Essex Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Aug. 25, 1955</u>		<u>A. L. Lewis</u>		<u>W. H. Archer</u>		<u>Benon Md</u>	

1. Name of decedent
 2. Date of death
 3. Place of death
 4. Cause of death
 5. Manner of death
 6. Name of physician
 7. Name of funeral home
 8. Name of next of kin
 9. Name of informant
 10. Date of report

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

02770

100-010-100

1. NAME OF DECEDENT Harriet F. Ford		2. DATE OF DEATH April 1, 1935	
3. PLACE OF DEATH Harriet F. Ford		4. CAUSE OF DEATH Heart Disease	
5. MANNER OF DEATH Heart Disease		6. NAME OF PHYSICIAN Dr. J. H. Ford	
7. NAME OF FUNERAL HOME Harriet F. Ford		8. NAME OF NEXT OF KIN Dr. J. H. Ford	
9. NAME OF INFORMANT Dr. J. H. Ford		10. DATE OF REPORT April 1, 1935	

BUREAU V. 2

APR 25 1935

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7789				07780			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 802							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Harford		MARYLAND		STATE Md		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (for this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Fallston		5 yrs		TOWN Fallston			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				Rural			
3. NAME OF DECEASED: (First) WILLIAM		(Middle) RUSSELL		(Last) AYRES		4. DATE OF DEATH (Month) (Day) (Year) Aug. 31 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Mar 24 1903	9. AGE last birthday: 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Railroad worker MOP		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Rocks Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Charles Ayers				14. MOTHER'S MAIDEN NAME: Susie Lutz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: 705-10-8788-Mrs Russell		17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Thrombosis of left coronary artery							
Antecedent cause(s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Paul F. Men		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/31/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: Sep 3, 55		NAME OF CEMETERY OR CREMATORY: Highland Presby.		LOCATION (City, town, or county) (State) Street Hfd Md	
DATE REC'D BY LOCAL REG: 9-1-55		REGISTRAR'S SIGNATURE: Russell S. Fotherwood		24. FUNERAL DIRECTOR: W. H. Archer		ADDRESS: Benson Md	

BUREAU V. S.

SEP 6 1955

RECEIVED

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INSTRUCTIONS

I

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07781

7774 CERTIFICATE OF DEATH

Reg. Dist. No. 18d

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
32 TOWN <u>Bel Air</u>		29 years		32 TOWN <u>Bel Air Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				414 Barnes St			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
George Melvin Bailey				Aug 10 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	MARRIED	Sept 30 - 1893	61 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Self Employed		Truck "Auto"		Alameda Md		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Walter F Bailey				Laura Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		215-22-8850		Mrs George Bailey 414 Barnes St Bel Air Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
METASTATIC CARCINOMA						6 Mo.	
ANTECEDENT CAUSE(S) DUE TO (B)						4 YRS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9:00, 1955, to Aug 9, 1955, that I last saw the deceased alive on 9:00, 1955, and that death occurred at 6:15 A.M. from the causes and on the date stated above.							
SIGNATURE <u>AP Adwell</u>				M. D. <u>Bel Air Md</u>		DATE SIGNED <u>10 Aug 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug 12/55		Mt Zion		Hartford Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 8-10-55		Purilla Louwood		Joseph J. J. Bell		Md	

EMOTIONALISM

THE ONLY WAY TO GET A TRUE PICTURE OF THE SITUATION IN THE MIDDLE EAST IS TO GO THERE AND SEE IT FOR YOURSELVES. THE PRESS AND THE RADIO HAVE GIVEN US A DISTORTED VIEW OF THE SITUATION. THE ONLY WAY TO GET A TRUE PICTURE OF THE SITUATION IN THE MIDDLE EAST IS TO GO THERE AND SEE IT FOR YOURSELVES.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

41781

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF NOTARY

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DEPUTY SHERIFF

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF OF POLICE

23. SIGNATURE OF DEPUTY CHIEF OF POLICE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF DEPUTY SHERIFF

26. SIGNATURE OF JAILER

27. SIGNATURE OF WARDEN

28. SIGNATURE OF CHIEF OF POLICE

29. SIGNATURE OF DEPUTY CHIEF OF POLICE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF DEPUTY SHERIFF

BUREAU V. 1

AUG 15 1955

RECEIVED

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7790

CERTIFICATE OF DEATH

07782

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Joppa, Rural		8 yrs.,		TOWN Joppa, Rural		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Andrew (Middle) - (Last) Birkholz				(Month) Aug. (Day) 3, (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	Widowed	Mar. 28, 1869	86 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Brick Layer		Home Construction		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Antone Birkholz				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		218-09-4035		Vernon Birkholz, Joppa, Maryland.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) Cachexia						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma large bowel						3 mo.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) (904.9)						1 yr.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Fracture rt. hip						3 mo.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
None							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/> <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from May 8, 1955 , to Aug. 3, 1955 , that I last saw the deceased alive on Aug. 1, 1955 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
William A. Tyson M.D.				Kingsville, Md. Aug. 4, 1955			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug. 6, 1955		Sacred Heart		German Hill Rd., Balto., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE Aug. 7, 1955		Norma G. Thayer		Howard K. McComas & Son Abingdon, Md.,			

Howard K. McComas & Son

CERTIFICATE OF DEATH

1739

Reg. No. 110

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Department of Health, at Baltimore, Maryland, this 9th day of August, 1935.

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

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BUREAU V. S.

AUG 9 1935

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7791

07783

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 182

Reg. Dist.

1. PLACE OF DEATH:

COUNTY Harford MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN Conowingo Village
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Harford
 CITY (If outside corporate limits write RURAL and give nearest town)
 TOWN Conowingo Village
 STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Elizabeth Amelia Carroll

4. DATE OF DEATH

(Month)

(Day)

(Year)

August 2

19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Female

White

Married

April 9, 1891

64 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1 Immediate cause

DUE TO

(a) Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

18. MEDICAL CERTIFICATION

Conowingo Village
Harford Co., Md. INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Donald E Palmer

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
 DEPUTY MEDICAL EXAMINER ☐
 M. D. ASSISTANT MEDICAL EXAM. 8/2/55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

August 3, 1955C. G. KirkH. S. BaileyHarford Co., Md.

RECEIVED

AUG 9 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7792

CERTIFICATE OF DEATH

07784

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Maryland		COUNTY Harford			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Aberdeen		1 day		TOWN Aberdeen		RURAL	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
US Army Hospital Aberdeen Proving Ground Md				RFD #2, Poplar Hill			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Theresa		(Middle) Ann		(Last) Connolly		(Month) August (Day) 7 (Year) 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Female	White	Single	6 August 1955	— yrs.	Months	Days	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		None		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Joseph Connolly Jr				Gertrude Mary Burgess			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		NA		Father (as in 2)			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A) Prematurity				INTERVAL BETWEEN ONSET AND DEATH 26 hours			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
None		NA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Aug 7 , 19 55 , to Aug 7 , 19 55 , that I last saw the deceased alive on 7 Aug , 19 55 , and that death occurred at 2015p M, from the causes and on the date stated above.							
SIGNATURE Robert Bernstein				DATE SIGNED 7 Aug 55			
ADDRESS US Army Hospital Aberdeen Md							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug 9-1955		Post Cemetery		Aberdeen Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
Aug 9-1955		Nellie R. Perry		John E. Soring			
DATE		ADDRESS					

2085201250

CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED PERSON'S NAME OR DESIGNATION

2. SEX ☐ Male ☐ Female

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESS

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

BUREAU V. S.

AUG 11 1955

RECEIVED

UNCLASSIFIED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7775

CERTIFICATE OF DEATH

07785

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Pa		COUNTY Burks			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Havre de Grace		2 hrs		TOWN Reading		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)					
553 Warren St.		100 Stanford Ave., Lincoln Park					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Rhoda F. Donahower				Aug. 10, 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED,	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White	Widowed	July 22, 1884	71 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
House Wife				Pennsylvania		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Thomas George				Mary A. Stonehead			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no				Clyde Donahower, Reading, Pa.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
Coronary Thrombosis						sudden	
ANTECEDENT CAUSE(S) DUE TO						3 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
Chronic Myocarditis & heart failure							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						none	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
none				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8/12/55, 19....., to 8/10/55, 19....., that I last saw the deceased alive on 8/10/55, 19....., and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
Joseph R. Lee		Havre de Grace, Md.		8-11-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		8-11-1955		Forest Hills		Reading, Pa.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Aug 11-1955		G. L. Lewis		Lee A. Patterson & Son		Perryville, Md.	

INSTRUCTIONS

STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

07325

Reg. Fee, \$1.00

1. FULL RESIDENT HOME OR FOREIGN

2. IN

3. DISEASE

4. PLACE OF DEATH

5. DATE OF DEATH

6. AGE

7. SEX

8. OCCUPATION

9. CAUSE OF DEATH

10. MEDICAL CERTIFICATION

Chronic myocarditis - heart failure

None

BUREAU V. 2

AUG 15 1955

RECEIVED

Rockville, Md.

Forest Hill

8-11-55

Unusual

John Pottersson, Rockville, Md.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07786

7776

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>HARVE DE GRACE</u>		<u>30 HRS.</u>		TOWN <u>BEL AIR</u>		<u>32</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>7 Lee ST.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>AQUILLA ROBERT HALL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 6 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>3-30-1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUTLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE FAMILY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley HALL</u>				14. MOTHER'S MAIDEN NAME <u>LAURA Johns</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>7 Lee Street Mrs. Bertha Hall - Bel-Air, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Toxemia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Mesenteric thrombosis ARIO.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Gangrene Left Leg - H.C.</u>							
DUE TO <u>ASCVD coronary artery disease</u>							
DUE TO <u>Left auricular thrombosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-5</u> , 19 <u>55</u> , to <u>8-6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-6</u> , 19 <u>55</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wm. K. Brendler</u>				ADDRESS (Street, city, town, state) <u>Harve de Grace Md</u>		DATE SIGNED <u>8-6-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		LOCATION (City, town, or county) (State) <u>Benson, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>G. L. Lembo M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Otelis J. Bullock</u>		ADDRESS <u>Harve de Grace Md.</u>	
DATE <u>Aug. 10-1955</u>							

ENCLOSURE

1. This form is to be filled out by the physician or other person who has attended the deceased and is to be submitted to the Bureau of Health Statistics, State Department of Health, Baltimore, Md. It is to be filled out for all deaths, except those which are reported to the Bureau of Health Statistics by the physician or other person who has attended the deceased.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD. CERTIFICATE OF DEATH

Form No. 10-1-54

A. DECEASED'S NAME (Last, first, middle initial)

B. SEX (Male or Female)

C. AGE (Years, months, days)

D. DATE OF BIRTH (Month, day, year)

E. PLACE OF BIRTH (City, town, village, or foreign country)

F. OCCUPATION (If deceased was engaged in any occupation, trade, or profession, state it here)

G. CAUSE OF DEATH (State the cause of death as far as known)

H. MANNER OF DEATH (State the manner of death as far as known)

I. SIGNATURE OF PHYSICIAN (If deceased was attended by a physician, state his name and signature)

J. SIGNATURE OF DECEASED (If deceased was capable of signing, state his name and signature)

K. SIGNATURE OF WITNESSES (If deceased was not capable of signing, state the names and signatures of two witnesses)

L. SIGNATURE OF REGISTRAR (If deceased was not capable of signing, state the name and signature of the registrar)

M. SIGNATURE OF CLERK (If deceased was not capable of signing, state the name and signature of the clerk)

N. SIGNATURE OF CHURCH CLERK (If deceased was not capable of signing, state the name and signature of the church clerk)

O. SIGNATURE OF MINISTER (If deceased was not capable of signing, state the name and signature of the minister)

P. SIGNATURE OF RABBI (If deceased was not capable of signing, state the name and signature of the rabbi)

Q. SIGNATURE OF PRIEST (If deceased was not capable of signing, state the name and signature of the priest)

R. SIGNATURE OF BISHOP (If deceased was not capable of signing, state the name and signature of the bishop)

S. SIGNATURE OF ARCHBISHOP (If deceased was not capable of signing, state the name and signature of the archbishop)

T. SIGNATURE OF PAPAL LEGATE (If deceased was not capable of signing, state the name and signature of the papal legate)

U. SIGNATURE OF APOSTOLIC NUNCIUS (If deceased was not capable of signing, state the name and signature of the apostolic nuncio)

V. SIGNATURE OF VICE-LEGATE (If deceased was not capable of signing, state the name and signature of the vice-legat)

W. SIGNATURE OF LEGATE (If deceased was not capable of signing, state the name and signature of the legat)

X. SIGNATURE OF APOSTOLIC DELEGATE (If deceased was not capable of signing, state the name and signature of the apostolic delegate)

Y. SIGNATURE OF APOSTOLIC PRO-NUNCIUS (If deceased was not capable of signing, state the name and signature of the apostolic pro-nuncio)

Z. SIGNATURE OF APOSTOLIC VICE-DELEGATE (If deceased was not capable of signing, state the name and signature of the apostolic vice-delegate)

AA. SIGNATURE OF APOSTOLIC DEPUTY-LEGATE (If deceased was not capable of signing, state the name and signature of the apostolic deputy-legat)

AB. SIGNATURE OF APOSTOLIC SECRETARY (If deceased was not capable of signing, state the name and signature of the apostolic secretary)

AC. SIGNATURE OF APOSTOLIC CHANCELLER (If deceased was not capable of signing, state the name and signature of the apostolic chancellor)

BUREAU V. S.

AUG 12 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7793

07789

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Hanford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Hanford</i>	
CITY (If outside corporate limits, write RURAL OR end, give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Army Chemical Center</i>		<i>5 weeks</i>		TOWN <i>Army Chemical Center</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>Quarters #292</i>				<i>Quarters #292</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>John</i> (Middle) <i>(N.M.I.)</i> (Last) <i>Hamilton</i>				(Month) <i>Aug.</i> (Day) <i>21</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. UNDER 1 YEAR		11. UNDER 24 HRS.
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Dec. 18, 1871</i>	<i>83</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Salesman, retired</i>		<i>Grocery</i>		<i>Canada</i>		<input checked="" type="checkbox"/>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>David Hamilton</i>				<i>Greta Pauline Swetha</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No.</i>		<i>#006-07-6517</i>		<i>St. Col. Allan R. Hamilton</i>		<i>Quarters #292</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
153X IMMEDIATE CAUSE (A)				GENERALIZED CARCINOMA OF STOMACH			
ANTECEDENT CAUSE(S) DUE TO (B)				ADENOCARCINOMA OF SIGMOID			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				GENERALIZED ARTERIOSCLEROSIS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<i>AUG. 59</i>		<i>ADENOCARCINOMA OF SIGMOID COLON</i>		<i>Cambridge, Md.</i>		<i>2035</i>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<i>MAY 1955</i>		<i>9:30 P.M.</i>		<i>from the causes and on the date stated above.</i>			
22. I hereby certify that I attended the deceased from <i>MAY 1955</i> , to <i>AUG 21, 1955</i> , that I last saw the deceased alive on <i>AUG 20, 1955</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<i>David A. Cap...</i>		<i>Army Chemical Center, MD</i>		<i>Aug 21, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Removal</i>		<i>8/23/55</i>		<i>Wt. Auburn Cemetery</i>		<i>Cambridge, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Aug 23-55</i>		<i>Hellie R. Perry</i>		<i>John F. Yarnig</i>		<i>Abbeville, Md.</i>	

42550

• **CHANGING**

BUREAU V. S.

AUG 21 1955

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
7794

07787

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Maryland		COUNTY Harford			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Edgewood		3 yrs		TOWN Edgewood			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Martha		(Middle) Elizabeth		(Last) Hancock		(Month) Aug. (Day) 18 (Year) 19 55	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
female	white	married	June, 24, 1876	79 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		none		Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Isaac Thompson				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		Mrs. Frank Jones, Edgewood, Maryland			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) CONGESTIVE HEART FAILURE						INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
ANTECEDENT CAUSE(S) DUE TO (B) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						5 YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) DISEASE							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. HYPERTROPHIC ARTHRITIS							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, term, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from SPRING, 19 55, to 18 AUG, 19 55, that I last saw the deceased alive on 18 AUG, 19 55, and that death occurred at 11 AM, from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
Ch. Stewart Jr.		Box 95, Edgewood, Md.		18 AUG 55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		Aug. 19, 1955		Seaver & Son F.H.		Marion, Smyth, Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
Aug. 19, 1955		Norma G. Moore		Howard K. McComas & Son Abingdon, Md.			

Howard K. McComas Jr.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

Reg. One No. 130

COUNTY OF DEATH BALTIMORE		CITY OF DEATH BALTIMORE	
NAME OF DECEASED JAMES H. HARRIS		SEX Male	
AGE 35 years		DATE OF DEATH July 15, 1955	
PLACE OF DEATH 1234 Main St.		CAUSE OF DEATH Heart Disease	
OCCUPATION Clerk		MANNER OF DEATH Natural	
MARITAL STATUS Single		EDUCATION High School	
BIRTH DATE Jan. 1, 1920		BIRTH PLACE Baltimore, Md.	
FATHER'S NAME John H. Harris		MOTHER'S NAME Mary E. Harris	
PREVIOUS RECORDS None		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CORONER (None)		SIGNATURE OF REGISTRAR (None)	

BUREAU V. S.

AUG 22 1955

RECEIVED

NOTIFICATION

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the county in which the death occurred.

7777 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Harford</i>	
CITY OR TOWN <i>Havre de Grace</i>		LENGTH OF STAY (in this place) <i>20 yrs</i>		CITY OR TOWN <i>Havre de Grace</i>		<i>24</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>827 S. Washington St.</i>				STREET ADDRESS (If rural give location) <i>827 S. Washington St.</i>			
3. NAME OF DECEASED (Type or Print) <i>MATHERINE MATHews HOPPER</i>				4. DATE OF DEATH (Month) <i>AUG</i> (Day) <i>4</i> (Year) <i>1955</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>WIDOWED</i>	8. DATE OF BIRTH <i>MAY 12 1866</i>	9. AGE last birthday <i>89</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>J. G. MATHEWS</i>				14. MOTHER'S MAIDEN NAME <i>HELEN SAPPINGTON</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT & ADDRESS <i>Mrs. S. Taylor Lyon - Havre de Grace Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio Sclerosis - Hypertension</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 26, 1955</i> to <i>Aug 6, 1955</i> , that I last saw the deceased alive on <i>July 26, 1955</i> , and that death occurred at <i>5-4</i> M, from the causes and on the date stated above.							
SIGNATURE <i>G. L. Lewis</i>				ADDRESS (Street, city, town, state) <i>Havre de Grace Md</i> DATE SIGNED <i>Aug 6-1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>8-6-1955</i>		NAME OF CEMETERY OR CREMATORY <i>ANGEL HILL</i>		LOCATION (City, town, or county) (State) <i>Havre de Grace, Md</i>	
24. REC'D BY REGISTRAR <i>Aug 6-1955</i>		REGISTRAR'S SIGNATURE <i>G. L. Lewis m.d.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>P. Madison Mitchell</i>		ADDRESS <i>Havre de Grace, Md.</i>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Form 100-100

1. PLACE OF DEATH

MARYLAND

COUNTY OF DEATH

CITY OF DEATH

STREET OF DEATH

APARTMENT OF DEATH

ZIP CODE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REASON FOR ENTRY

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

BUREAU V. S.

AUG 8 1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7778 CERTIFICATE OF DEATH

07791

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>24 HAVRE DE GRACE</u>		<u>17 Hrs 48 min</u>		TOWN <u>Aberdeen</u>		<u>31</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>71 HARFORD MEMORIAL HOSP</u>				STREET ADDRESS (If rural give location) <u>Box 414</u>			
3. NAME OF DECEASED (Type or Print) <u>Baby Boy Inbody</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 2 19 55</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>August 1, 1955</u>	9. AGE last birthday yrs. <u>17</u>		IF UNDER 1 YEAR <u>17</u> Months Days <u>48</u> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HAROLD Inbody</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Ann NEUBAUER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>SWAIN HARB HAROLD IN BODY OR DEL MO</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
761.0 IMMEDIATE CAUSE (A) <u>RESPIRATORY FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 HRS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>BRAIN STEM ANOXIA</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>MATERNAL PLACENTA ABRUPTIO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>8:1</u> , 19 <u>55</u> , to <u>8:2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8:2</u> , 19 <u>55</u> , and that death occurred at <u>5:00</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>B. B. Norman</u>				M.D.		ADDRESS (Street, city, town, state) <u>82:55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-3-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		LOCATION (City, town, or county) (State) <u>Havre de Grace Md.</u>	
24. REC'D BY REGISTRAR <u>Aug 3 1955</u>		REGISTRAR'S SIGNATURE <u>G. F. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>MD. HAVRE DE GRACE</u>	

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MAINTAIN STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Form No. 1

1. PLACE OF DEATH

2. NAME OF DECEASED

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. PLACE OF BIRTH

8. SEX

9. RACE

10. AGE

BUREAU V. S.

AUG 4 1955

RECEIVED

11. SIGNATURE

12. DATE

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RECEIVED
AUG 4 1955
BUREAU V. S.
RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07792

7795

CERTIFICATE OF DEATH

Reg. Dist. No. 182

Item 5, Film G186 9-20-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>HARFORD</u>		<u>3 years</u>		TOWN <u>Bel Air MD</u>		<u>32</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>County Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>ALICE</u> <u>JOHNSON</u>				<u>August 8</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Col.</u>	<u>Wid.</u>	<u>May 5-1873</u>	<u>82</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>House wife</u>		<u>HARFORD</u>		<u>US</u>	
13. FATHER'S NAME <u>Alexander CORNS</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Prigg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<u>JAMES A CORNS</u> <u>Bel Air MD PD</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							<u>12</u>
151X IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach</u>							
DUE TO ANTECEDENT CAUSE(S) (B) <u>None</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>None</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 1</u> , 19 <u>55</u> , to <u>Aug. 8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug. 7</u> , 19 <u>55</u> , and that death occurred at <u>9:30M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>8-8-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>BURIAL</u>	<u>Aug. 1/1955</u>	<u>Assbury Methodist</u>		<u>Bel Air Harford Md</u>		<u>Rural</u>	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
DATE <u>8-9-55</u>	<u>Pravilla Howard</u>	<u>Joseph L. Foster</u>		<u>Bel Air Md</u>			

ENCLOSURE

AUG 12 1955

RECEIVED

March 9, 1901

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7779

CERTIFICATE OF DEATH

07793

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAURE DE GRACE</u>		LENGTH OF STAY (In this place) <u>1 1/2 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CONOWINGO</u>		<u>07X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>				STREET ADDRESS (If rural give location) <u>R.D.</u>			
3. NAME OF DECEASED (Type or Print) <u>EDWARD</u> (First) <u>JONES, JR.</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>August</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>FEB. 18 1930</u>	9. AGE last birthday <u>25</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>EDWARD JONES SR.</u>				14. MOTHER'S MAIDEN NAME <u>MARION BARRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>			16. SOCIAL SECURITY NO. <u>214-26-7957</u>		17. INFORMANT & ADDRESS <u>Ocellous Jones Conowingo, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
438.0 IMMEDIATE CAUSE (A) <u>Uremia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Acute Bacterial Endocarditis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/31</u> , 19 <u>55</u> , to <u>8/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/3</u> , 19 <u>55</u> , and that death occurred at <u>1:25</u> M., from the causes and on the date stated above. SIGNATURE <u>George T. Stansbury</u> M.D. ADDRESS (Street, city, town, state) <u>569 Revolution St, Haure de Grace, Md.</u> DATE SIGNED <u>8/3/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug. 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wht. Zoon</u>		LOCATION (City, town, or county) (State) <u>near Conowingo, Md.</u>	
24. REC'D-BY REGISTRAR DATE <u>Aug. 6-1955</u>		REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Tyson</u>		ADDRESS <u>Rising Sun Md.</u>	

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7780

CERTIFICATE OF DEATH

07788

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Pr. Geo.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HAURE DE GRACE</u>		<u>7 HRS.</u>		TOWN <u>HYATTSVILLE</u>		<u>16-15-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL Hosp.</u>				STREET ADDRESS (If rural give location) <u>507 Chillum Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>SAMUEL</u> (First) <u>KASTEN</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>AUGUST 11, 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>DEC-22-1922</u>	9. AGE last birthday <u>32</u> yrs.		<input checked="" type="checkbox"/> UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ARKANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM KASTEN</u>				14. MOTHER'S MAIDEN NAME <u>DORA MIRSKY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>HARRY KASTEN - Brother</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Acute myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary atherosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 11</u>, 19<u>55</u>, to <u>Aug 11</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Aug 11</u>, 19<u>55</u>, and that death occurred at <u>8:25</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>B. J. Phinkett Jr</u>		M.D. <u>617 W. Belair Ave. Baltimore, Md.</u>		DATE SIGNED <u>Aug 12 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Aug 14 1955</u>		NAME OF CEMETERY OR CREMATORY <u>NAT'L. HEBREW CAP. Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore DC</u>	
24. REC'D BY REGISTRAR <u>Aug 13-1955</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George T. Hume</u>		ADDRESS <u>4217-9th Ave</u>	

03788

CERTIFICATE OF DEATH

Reg. Dist. No.

1. USUAL RESIDENCE (MOTHER OR FATHER)

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. MEDICAL EXAMINATION

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF CLERK

16. PLACE OF BIRTH

BUREAU V. S.

AUG 15 1955

RECEIVED

RECEIVED
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS
JANUARY 10 1956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 21f Film 0180 9-8-55 am

7796

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07794
Reg. Dist.

No. 180

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Harford		MARYLAND		STATE Maryland COUNTY Harford			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN Abingdon				TOWN Bel Air <input checked="" type="checkbox"/>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) William		(Middle) L.		(Last) Magness		4. DATE OF DEATH (Month) August (Day) 26 (Year) 55	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Dec. 21, 1889	9. AGE last birthday: 65 yrs.	IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Foreman		10b. KIND OF BUSINESS OR INDUSTRY: Gas & Electric		11. BIRTHPLACE (State or foreign country): Abingdon, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: John R. Magness				14. MOTHER'S MAIDEN NAME: Mary E. Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No.: 212-05-5903		17. INFORMANT & ADDRESS: Minnie I. Magness, Bel Air, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <p>8/22 Immediate cause</p> <p>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last</p> </div> <div style="width: 50%;"> <p>(a) Compound, comminuted fracture skull DUE TO</p> <p>(b) _____ DUE TO</p> <p>(c) _____</p> </div> </div>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Compound fracture both bones both legs							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY 15 Aug 50		21c. (City or town) Abingdon (County) Harford (State) MD			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY Aug. 26, 1955 9 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Auto-Pedestrian			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> 8/27/55					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF Aug. 29, 1955		NAME OF CEMETERY OR CREMATORY St. Francis,		LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland	
DATE REC'D BY LOCAL REG. Aug 28, 1955		REGISTRAR'S SIGNATURE Norma G. Moore		24. FUNERAL DIRECTOR Howard K. McConas & Son ADDRESS Abingdon, Md.			

BUREAU V. S.

AUG 30 1935

RECEIVED

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07795

7797

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>MD</u> COUNTY <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Street</u>		LENGTH OF STAY (In this place)		OR TOWN <u>Street RD</u>		OR TOWN <u>Street RD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Blanche</u>		(Middle) <u>E</u>		(Last) <u>Murray</u>		(Month) <u>8</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>4-14-1914</u>		9. AGE last birthday <u>41</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>0</u> (Days) <u>0</u> (Hours) <u>0</u> (Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Presbury</u>				14. MOTHER'S MAIDEN NAME <u>Annie Whittington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>Earl G Murray Street MD Box 93 AB</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 28, 1950</u> , to <u>Aug. 15, 1955</u> , that I last saw the deceased alive on <u>Aug. 4, 1955</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthel</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>8-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Clarks Chapel</u>		LOCATION (City, town, or county) (State) <u>Belt Air Rural</u> <u>MD</u>	
24. REC'D BY REGISTRAR <u>8-16-55</u>		REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster Belair</u>		ADDRESS	

03105

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

729

Reg. Case No. 164

1. AGE AND SEX OF DECEASED

37 T 2
M

2. RACE AND COLOR

WHITE

3. PLACE OF BIRTH

MD

4. PLACE OF DEATH

MD

5. DATE OF DEATH

1955

6. TIME OF DEATH

10:00 PM

7. CAUSE OF DEATH

Heart Disease

8. DISEASE OR INJURY

Myocardial Infarction

9. PLACE OF BIRTH

MD

10. PLACE OF DEATH

MD

11. DATE OF DEATH

1955

12. TIME OF DEATH

10:00 PM

13. CAUSE OF DEATH

Heart Disease

14. DISEASE OR INJURY

Myocardial Infarction

15. PLACE OF BIRTH

MD

16. PLACE OF DEATH

MD

17. DATE OF DEATH

1955

18. TIME OF DEATH

10:00 PM

19. CAUSE OF DEATH

Heart Disease

20. DISEASE OR INJURY

Myocardial Infarction

21. PLACE OF BIRTH

MD

22. PLACE OF DEATH

MD

23. DATE OF DEATH

1955

24. TIME OF DEATH

10:00 PM

25. CAUSE OF DEATH

Heart Disease

26. DISEASE OR INJURY

Myocardial Infarction

27. PLACE OF BIRTH

MD

28. PLACE OF DEATH

MD

29. DATE OF DEATH

1955

30. TIME OF DEATH

10:00 PM

31. CAUSE OF DEATH

Heart Disease

RECEIVED

1955 AUG 18

BUREAU V. S.

AUG 18 1955

RECEIVED

Aug 18/55

1955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7798 07796

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 180

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Harford	MARYLAND	STATE Maryland	COUNTY Harford
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Edgewood		CITY (If outside corporate limits write RURAL and give nearest town) TOWN Edgewood	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) John (First) Francis (Middle) Norris (Last)		4. DATE OF DEATH August 11 (Month) 19 (Day) 55 (Year)	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Feb. 14, 1919
9. AGE last birthday: 36 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Typewriter Mechanic		12. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.,	
13. FATHER'S NAME: James A. Norris		14. MOTHER'S MAIDEN NAME: Louise Goodwin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: 217-12-6372	
17. INFORMANT & ADDRESS: Anis L. Norris, Edgewood, Maryland.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
430.0 Immediate cause (a) Subacute bacterial endocarditis DUE TO Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause (b) stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE Howard C. Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 8/11/55 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Aug. 13, 1955	NAME OF CEMETERY OR CREMATORY St. Stephen's	LOCATION (City, town, or county) (State) Bradshaw, Balto., Maryland.
DATE REC'D BY LOCAL REG. Aug 11, 1955	REGISTRAR'S SIGNATURE Norma G. Moore	FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon Md.	

BUREAU V. 2

AUG 15 1955

RECEIVED

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7781

CERTIFICATE OF DEATH

07797

Reg. Dist. No. 1865

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Narford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Narford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Naude de Grace</i>				TOWN <i>Gberdeen - Md.</i>		31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
71 <i>Narford Memorial Hosp</i>				50 <i>Taft St</i>		1	
3. NAME OF DECEASED (Type or Print) <i>Oren</i> (First) <i>Elmer</i> (Middle) <i>Porter</i> (Last)				4. DATE OF DEATH (Month) <i>Aug</i> (Day) <i>1</i> (Year) <i>1955</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>11-27-03</i>		9. AGE last birthday <i>51</i> yrs.	IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Oil Burner Govt.</i>		11. BIRTHPLACE (State or foreign country) <i>Gross Creek - N.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Reid Porter</i>				14. MOTHER'S MAIDEN NAME <i>Florence Reedy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>224-03-0792</i>		17. INFORMANT & ADDRESS <i>Mrs Oren E. Porter</i> <i>Gberdeen Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
162X IMMEDIATE CAUSE (A) <i>Bronchogenic carcinoma</i>							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While et work Not while et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 1, 1955, to Aug 1, 1955, that I last saw the deceased alive on Aug 1, 1955, and that death occurred at 10:14 A.M. from the causes and on the date stated above.							
SIGNATURE <i>B. J. Blunkett, Jr.</i>				ADDRESS (Street, city, town, state) <i>617 W. Below Ave. Aberdeen Md</i>		DATE SIGNED <i>8-2-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Aug 3-1955</i>		NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		LOCATION (City, town, or county) (State) <i>Bel Air Harford Co. Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Aug 3-1955</i>		<i>G. L. Lewis M.D.</i>		<i>John G. Tarrington</i>		<i>Aberdeen Md.</i>	

THIS IS A SUMMARY OF THE INFORMATION RECEIVED FROM THE BUREAU OF VITAL STATISTICS, BALTIMORE, MARYLAND, CONCERNING THE DEATH OF THE ABOVE NAMED PERSON. THE INFORMATION IS BASED ON THE REPORT OF THE PHYSICIAN WHO ATTENDED THE DECEASED, AND ON THE RECORDS OF THE BUREAU OF VITAL STATISTICS. THE INFORMATION IS NOT GUARANTEED AS TO ITS ACCURACY, AND IS NOT TO BE USED FOR ANY PURPOSE OTHER THAN THAT FOR WHICH IT WAS OBTAINED.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1955</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. DATE OF REGISTRATION <i>Jan 15 1955</i>		12. OFFICE OF REGISTRAR <i>Baltimore, Md.</i>	

BUREAU V. S.

AUG 4 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7799

CERTIFICATE OF DEATH

07798

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Churchville		Lifetime		TOWN Churchville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Joseph Harvey Scarborough				Aug. 5 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
male	white	widowed	May, 31, 1866	89			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Proprietor		Drug Store		Harford Co., Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Samuel J. Scarborough				Amelia Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		H. Miller Scarborough, Churchville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <i>Anteur edentit CVD disease</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 19 55</i> , to <i>Aug 5 19 55</i> , that I last saw the deceased alive on <i>Aug 5 19 55</i> , and that death occurred at <i>5:30 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Ralph H. H. H.</i>				ADDRESS (Street, city, town, state) <i>Churchville, Md.</i> DATE SIGNED <i>Aug 5</i>			
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Aug. 8, 1955		Churchville Presbyterian		Churchville, Harford, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE <i>8-8-55</i>		<i>Pravilla Lowndes</i>		<i>Howard K. McConas & Son, Abingdon, Md.</i>			

CERTIFICATE OF DEATH

1935

Reg. No. 102

NAME OF DECEASED

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

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JOHN WILLIAM

JOHN WILLIAM

JOHN WILLIAM

BUREAU V. S.

AUG 10 1935

RECEIVED

7800

CERTIFICATE OF DEATH

07799

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>MD.</i>		COUNTY <i>HARFORD</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>RURAL ABERDEN</i>		30 YRS.		TOWN <i>RURAL ABERDEN</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <i>T.P.D. # 1</i>				<i>P.D. # 1</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <i>GERTIE AMELIA SEWARD</i>				(Month) (Day) (Year) <i>AUG. 30 1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>FEMALE</i>	<i>WHITE</i>	<i>WIDOWED</i>	<i>AUG. 10 1879</i>	<i>76</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>HOUSE WIFE</i>		<i>HOME</i>		<i>MD.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Josiah GROSS</i>				<i>ALICE CHRISTINE CASTLE</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>NO</i>		<i>—</i>		<i>PAUL H. SEWARD ABERDEN MD.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<i>1 year</i>	
199.9 IMMEDIATE CAUSE (A) <i>Carcinomatosis - Primary site unknown</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb</i> , 19 <i>55</i> , to <i>Aug 30</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>Feb 30</i> , 19 <i>55</i> , and that death occurred at <i>2:00 PM</i> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Frederick J. Stetson M.D.</i>				<i>Philip Blotz ABERDEN MD</i>		<i>8/31/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<i>BURIAL</i>	<i>SEPT. 1 1955</i>	<i>REFORM CEM.</i>		<i>MIDDLETOWN</i>		<i>MD.</i>	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			
<i>Aug 31 - 55</i>	<i>Nellie R. Perry</i>	<i>R. Madison Mitchell</i>		<i>HAVRE DE GRACE MD.</i>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom of the certificate may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

07398

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Reg. Dist. No.

DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME OF DECEASED

MR

DATE OF DEATH

SEP 1 1955

RD #1

DECEASED'S RESIDENCE

RD #1

George America Edwards

FEMALE WHITE

WEDDED 11/12/27 20

PROSE WIFE

MR

W. 2 A

Wife Christine Carter

John Gross

Wife H. Edwards

IN WEDDED CERTIFICATION

BUREAU V. 2

SEP 2 1955

RECEIVED

SEP 1 1955 THE FORM 501

Wife H. Edwards

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07800

7782

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Hartford</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Hartford</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Horne-deGrace</u>	<u>24 hrs.</u>	TOWN <u>Box 168, R.D. #1 Bel Air, x</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>71 Hartford Memorial Hospital</u>		<u>1</u>	
3. NAME OF DECEASED		4. DATE OF DEATH	
(First) <u>Baby</u>	(Middle) <u>boy</u>	(Last) <u>Shelley</u>	(Month) <u>8</u> (Day) <u>28</u> (Year) <u>1955</u>
5. SEX		6. COLOR OR RACE	
<u>Male</u>	<u>White</u>		
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Newborn</u>		<u>Aug. 27, 1955</u>	
9. AGE last birthday		10. IF UNDER 1 YEAR	
<u>—</u> yrs.		Months <u>—</u> Days <u>—</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Shelley, Julian E.</u>		<u>Holmes, Bertha</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>(If Yes, give war or dates of service)</u>		<u>—</u>	
17. INFORMANT & ADDRESS			
<u>Shelley, Julian, Bel Air Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
762.5 IMMEDIATE CAUSE (A)		<u>Respiratory failure</u>	
ANTECEDENT CAUSE(S) DUE TO (B)		<u>atelectasis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)		<u>Prematurity (maternal hydramnios)</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
<u>—</u>		<u>—</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
<u>—</u>		<u>—</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<u>—</u>		<u>—</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>—</u>		<u>—</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<u>—</u>		<u>—</u>	
21f. HOW DID INJURY OCCUR?			
<u>—</u>		<u>—</u>	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
<u>Joseph T. Foster</u>		<u>Home de Grace</u>	
DATE		DATE SIGNED	
<u>Aug 31, 1955</u>		<u>8-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Bel Air Memorial Gardens</u>	
DATE THEREOF		LOCATION (City, town, or county) (State)	
<u>Aug 29, 1955</u>		<u>Bel Air Md</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>Th. L. Lewis</u>		<u>Joseph T. Foster</u>	
DATE		ADDRESS	
<u>Aug 31, 1955</u>		<u>Bel Air Md</u>	

2085192382

ACTA OF
 THE
 JUNE 10
 1955
 RECEIVED
 22 JUL 21 1955

DATE

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

23. REMOVAL (SPECIFY)
 BURIAL CHARGE

RECEIVED

AUG 31 1955

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

93000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7783

CERTIFICATE OF DEATH

Reg. Dist. No. 07801/81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Aberdeen</u>				TOWN <u>Aberdeen</u>		31	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>33 Wt. Royal Ave.</u>				STREET ADDRESS (If rural give location) <u>33 Wt. Royal Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Helen</u> (First) <u>Wells</u> (Middle) <u>Thompson</u> (Last)				4. DATE OF DEATH (Month) <u>Aug.</u> (Day) <u>16th</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 19th 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Luther Stewart Osborn</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Rebecca Wells.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>#207 E. 2nd St. Harry E. Osborn Aberdeen Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Ventricular Fibrillation</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Infarction</u>				<u>2 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Coronary Occlusion</u>				<u>2 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>5:00 AM</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 6, 1955</u> to <u>Aug 16, 1955</u> , that I last saw the deceased alive on <u>July 6, 1955</u> , and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Pith P. Robinson</u>		M.D. <u>8 Law St., Aberdeen, Md.</u>		DATE SIGNED <u>5-17-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Aug 19-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		LOCATION (City, town, or county) (State) <u>Aberdeen, Maryland.</u>	
24. REC'D BY REGISTRAR <u>Aug. 19-55</u>		REGISTRAR'S SIGNATURE <u>Mellie R. Perry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		ADDRESS <u>Aberdeen Md.</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

IN MEDICAL RECORDS OF DEPARTMENT

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

PLACE OF INTERMENT

DATE OF INTERMENT

PLACE OF EXHUMATION

DATE OF EXHUMATION

PLACE OF REINTERMENT

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BUREAU V. 3
JUG 22 1955

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NOTIFICATION

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PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

PLACE OF INTERMENT

DATE OF INTERMENT

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7784 CERTIFICATE OF DEATH

07802

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
31 TOWN <i>Aberdeen</i>				31 TOWN <i>Aberdeen</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100 #407 Edmund street.				#407 Edmund St. 1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Teena</i> (Middle) <i>Charlotte</i> (Last) <i>Tobin</i>				(Month) <i>Aug</i> (Day) <i>21</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. UNDER 1 YEAR		11. IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>Jan 21-1890</i>	<i>65</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>House</i>		<i>Balto. Maryland</i>		<i>USA</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Henry Jacobs</i>				<i>Margaret (unknown) Jacobs</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>none</i>		<i>Alfred F. Tobin Aberdeen Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <i>Cerebral arteriosclerosis</i>						<i>18 mos.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive Cardiovascular disease</i>						<i>UNK.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>AUG 6</i> , 19 <i>55</i> , to <i>AUG 21</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>AUG 20</i> , 19 <i>55</i> , and that death occurred at <i>1 P.</i> M, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>B. J. Plunkett, Jr.</i>		<i>8/24/55</i>		<i>Bakers cemetery</i>		<i>Aberdeen Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Burial</i>		<i>Aug 23-55</i>		<i>John G. Farving</i>		<i>Aberdeen Md.</i>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7785

CERTIFICATE OF DEATH

07803

Reg. Dist. No. 185-

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY OR TOWN <i>Harre-de-Grace</i>		LENGTH OF STAY (in this place) <i>about 25 yrs</i>		CITY OR TOWN <i>Harre-de-Grace</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hospital</i>				STREET ADDRESS <i>609 Pink Alley</i>			
3. NAME OF DECEASED (Type or Print) <i>AL Fred L Vaughn</i>				4. DATE OF DEATH (Month) <i>August</i> (Day) <i>30</i> (Year) <i>1955</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3-17-1897</i>	9. AGE last birthday <i>58</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>unemployed</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Alexander Vaughn</i>				14. MOTHER'S MAIDEN NAME <i>Rena (unknown)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>609 Pink Alley Mrs. Virginia Lane-Harre de Grace, Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE (A) <i>Cardiac Failure</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Diabetes Mellitus & Azotemia</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arteriosclerosis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Prostatism (Benign)</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>8/2</i> , 19 <i>55</i> , to <i>8/30</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>8/30</i> , 19 <i>55</i> , and that death occurred at <i>8:20</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>George T. Stansbury, M.D.</i>				ADDRESS (Street, city, town, state) <i>569 Revolution St. Fide. Md.</i>		DATE SIGNED <i>8/31/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Sept. 3, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>St. James A.M.E. Cem</i>		LOCATION (City, town, or county) (State) <i>Harre de Grace, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullock</i>		ADDRESS <i>Harre de Grace, Md.</i>	
DATE <i>Sept. 2 - 1955</i>							

07503

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Sept 5, 1935</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
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73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
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91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

BUREAU V. S.

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BALTIMORE
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DEPT. OF HEALTH
BALTIMORE

7891

07804

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 182

1. PLACE OF DEATH:

COUNTY

Harford

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
 TOWN

Benson

LENGTH OF STAY (in this place)
 5 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

CITY (If outside corporate limits write RURAL and give nearest town)
 TOWN

Balto

3Y01-4

STREET ADDRESS

(If rural, give location)

3. NAME OF DECEASED:
 (Type or Print)

(First)

Mary

(Middle)

Shene

(Last)

Vetter

4. DATE OF DEATH

(Month)

(Day)

(Year)

August 16

19 55

5. SEX:

Female

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Married

8. DATE OF BIRTH:

Mar 24-1906

9. AGE last birthday:

49 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Remix W. Va

12. CITIZEN OF WHAT COUNTRY:

U.S.

13. FATHER'S NAME:

Walter T. Givens

14. MOTHER'S MAIDEN NAME:

Sarah Louie Kinsley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

219-10-6528

17. INFORMANT & ADDRESS:

Mrs Ruth Lineberry Bel Air Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

170X

Immediate cause

(a) DUE TO

Carcinoma heart with wide metastasis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

Aug 1953 Carcinoma Left breast

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Gerald E Palmer

CHIEF MEDICAL EXAMINER

DATE SIGNED

DEPUTY MEDICAL EXAMINER

M. D. ASSISTANT MEDICAL EXAM.

8/16/55

23. BURIAL, CREMATION, REMOVAL (Specify):

Burial

DATE THEREOF

Aug 18, 1955

NAME OF CEMETERY OR CREMATORY

Oak Grove Cemetery

LOCATION (City, town, or county)

Balto Md

(State)

DATE REC'D BY LOCAL REG.

8-17-55

REGISTRAR'S SIGNATURE

Priscilla Foxworth

24. FUNERAL DIRECTOR

W. S. Tucker

ADDRESS

Benson Md

MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

AUG 19 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7802

07805

Reg. Dist.

No. 181

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Udinst</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS _____		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Udinst</u> <input checked="" type="checkbox"/> STREET ADDRESS _____ (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print) <u>Verdie FAYL West</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>August 10</u> 19 <u>55</u> (Month) (Day) (Year)	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/9/1902</u>
9. AGE last birthday: <u>53</u> yrs.		10. DATE OF BIRTH: <u>5/9/1902</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>David Grace</u>		14. MOTHER'S MAIDEN NAME: <u>Sabell M. Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Louis Johnson, Abertown, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>191X</u> Immediate cause (a) <u>Carcinoma, squamous cell,</u> DUE TO <u>Oral in place cheek with</u> Antecedent cause(s) (b) <u>wide metastasis</u> Diseases or conditions, if any, giving rise to the above cause DUE TO _____ stating underlying cause last (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			
19a. DATE OF OPERATION: _____		19b. MAJOR FINDING OF OPERATION: _____	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. HOW DID INJURY OCCUR? _____	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	
21c. (City or town) _____ (County) _____ (State) _____		21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY _____ M.	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Gerald C Palmer</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/10/55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>8/13/55</u> NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u> LOCATION (City, town, or county) <u>Churchville, Md.</u> (State) _____	
DATE REC'D BY LOCAL REG. <u>Aug 13, 1955</u>		REGISTRAR'S SIGNATURE <u>Bethel B. Wright</u> 24. FUNERAL DIRECTOR <u>Charles J. Smith</u> ADDRESS <u>St. Louis, Mo.</u>	

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AUG 18 1955

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07806

7786

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Pa</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
32 TOWN <u>Belt Air Md</u>		3 Months		TOWN <u>Philadelphia</u>		75x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Ethel</u> (Middle) <u>L</u> (Last) <u>Williams</u>				<u>Aug 6</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>(C)</u>	<u>Widowed</u>	<u>Nov 22-1898</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Housewife</u>		<u>Brunswick Ga</u>		<u>US</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>(O Alwaddell)</u>				<u>Emma (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>(Yes, no, or unk.)</u>		<u>(If Yes, give war or dates of service)</u>		<u>Belt Air, Md</u> <u>Mrs Arvata Chambers</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
174X IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>						<u>1 WEEK</u>	
ANTECEDENT CAUSE(S) DUE TO <u>CARCINOMATOSIS</u>						<u>1 YEAR</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>CARCINOMA OF UTERUS</u>						<u>12 YRS</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 1955</u> to <u>6 Aug 1955</u> , that I last saw the deceased alive on <u>1 Aug 1955</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>J. P. Bradwell</u>		<u>Belt Air Md</u>		<u>6 Aug 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 8-1955</u>		<u>Rollin Green</u>		<u>Philadelphia Pa</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8-6-55</u>		<u>Bevilla Lowwood</u>		<u>Joseph Foster Bel Air Md</u>			

CERTIFICATE OF DEATH

1. USUAL RESIDENCE (PRINT OR TYPE) 2. PLACE OF DEATH

3. SEX 4. AGE 5. RACE 6. OCCUPATION

7. DATE OF DEATH 8. TIME OF DEATH 9. CAUSE OF DEATH

10. MANNER OF DEATH 11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES 13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER 15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE 17. SIGNATURE OF CLERK

18. SIGNATURE OF REGISTRAR 19. SIGNATURE OF OFFICIAL

20. SIGNATURE OF OFFICIAL

BUREAU V. S.

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VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07807

7787

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <u>Harford</u> <u>Maryland</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>117 N. Stokes</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harford</u> STREET ADDRESS (If rural give location) <u>117 N. Stokes</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Albert</u> (Middle) <u>H.</u> (Last) <u>Wood</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>8/14/55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>5/2/1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) <u>Self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Harford County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Wood</u>				14. MOTHER'S MAIDEN NAME <u>Rosann Dennis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Elizabeth Wood, Harford</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 151X IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)						18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>8-11</u> , 19 <u>53</u> , to <u>8-13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/13</u> , 19 <u>55</u> , and that death occurred at <u>6 A.</u> M. from the causes and on the date stated above. SIGNATURE <u>A. L. Lewis M.D.</u> ADDRESS (Street, city, town, state) <u>Harford, Md.</u> DATE SIGNED <u>8/15/55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>8/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		LOCATION (City, town, or county) (State) <u>Harford County, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Aug. 15-55</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin J. Perry</u>		ADDRESS <u>Harford, Md.</u>	

BUREAU V. 8

AUG 17 1955

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AUG 8 1955

BUREAU V. S.